

# PEACE OFFICER CONDITIONS OF EMPLOYMENT FOR VISUAL ACUITY

SSB 07E (3/01)

**NAME:** \_\_\_\_\_

(PLEASE PRINT OR TYPE)

**SOCIAL SECURITY**

**NO:** \_\_\_\_\_

**EXAM**

**ID:** \_\_\_\_\_

"I understand that I do not meet the minimum visual acuity requirements for the Peace Officer position indicated by a check mark below.

☐

Correctional  
Officer

☐

Correctional  
Counselor I

☐

Parole  
Agent I

☐

Medical Technical  
Assistant

☐

Fire Fighter

The minimum visual acuity requirements are as follows:

**Classification**

**Visual Acuity Requirements**

- |                               |   |
|-------------------------------|---|
| • Correctional Officer        |   |
| • Correctional Counselor I    | 20/60 uncorrected in each eye and corrected to 20/20  |
| • Parole Agent I              |   |
| • Fire Fighter, CF            | 20/100 uncorrected in each eye and corrected to 20/20 |
| • Medical Technical Assistant | 20/200 uncorrected in each eye and corrected to 20/20 |

I declare that my visual acuity condition, known as *distance vision myopia*, was present at the time that the California Department of Corrections (CDC) offered me employment.

I certify that I am currently, and have been for the past 12 months (prior to employment), a bonafide, successful contact lens (hard, semi-rigid, or soft) wearer. I understand that my use of soft contact lens (SCL) is permitted as a reasonable accommodation to my vision and that I have a corrected visual acuity of 20/20 or better in each eye. I have verified through my Ophthalmologist/Optometrist that I have been a successful contact lens (hard, semi-rigid, or soft) wearer for the past 12 months prior to employment. *As a condition of employment with the CDC, I agree to submit to the following:*

- To wear SCLs at all times while on the job and that if I am unable to permanently wear my SCLs or refuse to wear my SCLs, I will notify my supervisor and the Institution's Return to Work Coordinator (RTWC), and understand that I may be removed from peace officer status.
- To participate in unannounced audits by my supervisor or the official designated by my hiring authority to routinely verify that the SCLs are actually being worn while on duty.
- To provide the Selection and Standards Branch and the RTWC with an annual report from my Optometrist or Ophthalmologist verifying that I am continuing to be a successful SCL wearer.
- To acknowledge that if I am temporarily unable to wear my SCLs, that glasses and hard or semi-hard contact lenses may not be substituted for SCL use, and that I will not be allowed to return to full duty until I provide a doctor's certification that I can safely wear my SCLs.

By my signature below, I acknowledge that I have read and accept the conditions of employment as listed above:"

**SIGNATURE:** \_\_\_\_\_

**DATE:** \_\_\_\_\_

This form is maintained by:

Preemployment Medical Unit  
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